City of Milwaukee
Department of Employee Relations
Employee Benefits Division

How To Complete the Health Plan Enrollment Application

GENERAL INSTRUCTIONS

Read this entire section

1) **Write the name of the Health Plan you have selected** (from the list below under Specific Instructions) **in Box 1 of Section A of the Health Plan Enrollment Form.**

2) Please Read the **SPECIFIC INSTRUCTIONS** below for the Health Plan you have selected. **Reminder: All Health plans, except the Basic Plan, the Basic Plan Tier 1 and the Basic Plan Tier 2, require physician selection for the subscriber and all dependents.**

3) Complete all sections of the Health Enrollment form as they apply to you. In Section B, list each eligible dependent, including their Social Security Number and their relationship to you (the subscriber). The **"Est. Patient"** column requires a "Yes" or "No" response to the question "Is the dependent an established patient of the physician selected?" Please mark the appropriate box. **Social Security numbers for each dependent are required.** Failure to provide complete information where it is required will cause delays in setting up your membership as well as delays in the issuance of ID cards.

4) **ACTIVE EMPLOYEES**: Return your completed application to your department payroll clerk within the designated Open Enrollment period. Late applications will not be accepted for any plan changes. See the Open Enrollment booklet for more information on the Open Enrollment period. **DO NOT** mail your application to the Health Plan.

5) **RETIREES, DISABILITY RETIREES, and SURVIVING SPOUSE ENROLLEES**: Mail your completed application to **Employes' Retirement System, 200 E. Wells St., Rm 603 City Hall, Milwaukee, WI 53202**. **DO NOT** mail your application to the Health Plan.

6) A Domestic Partnership registration must be completed before enrolling a Domestic Partner for Health/Dental Insurance.

SPECIFIC INSTRUCTIONS

Read the instructions for the HEALTH PLAN of your choice.

The following health plans are available to all active employees. Retirees should check the zip code listing in the Open Enrollment Booklet. If the HMO you wish to select is not available in your zip code, you must select another HMO health plan.

City of Milwaukee
Department of Employee Relations
Employee Benefits Division

AVAILABLE HEALTH PLAN CHOICES

CompcareBlue – AURORA FAMILY NETWORK HMO

SECTION A Write **"Aurora Family Network"** in BOX 1 and your Health Center selection in BOX 2. Please indicate the Primary Care Physician (PCP) name and 4-digit provider number in Box 3.

SECTION B **Please indicate the Primary Care Physician (PCP) name and 4-digit provider number for each family member listed.** List each eligible dependent and include the Date of Birth, the Social Security Number and their relationship to you. Each family member may select a PCP from a different physician group (IPA) or clinic. Female members do not need to select an OB/GYN. Please refer to the Aurora Family HMO directory for information regarding OB/GYN utilization

CompcareBlue - BROAD NETWORK HMO

SECTION A Write "**CompcareBlue Broad**" in BOX 1, Leave BOX 2 blank.

Please indicate the Primary Care Physician (PCP) name and 4-digit provider number in BOX3.

SECTION B Please indicate the Primary Care Physician (PCP) name and 4-digit provider number for each family member listed. Each family member may select a PCP from a different physician group (IPA) or clinic. Female members do not need to select an OB/GYN. Please refer to the CompcareBlue Traditional HMO directory for information regarding OB/GYN utilization.

BASIC HEALTH PLAN - (BC/BS CMS)

SECTION A Write "Basic Plan" in BOX 1. Leave BOX 2, BOX 3 & "PHYSICIAN SELECTION" boxes blank.

BASIC PLAN TIER 1 - (BC/BS CMS)
BASIC PLAN TIER 2 – (BC/BS CMS)

SECTION A Write "**Basic Plan Tier 1" or "Basic Plan Tier 2**" in BOX 1. Leave BOXES 2 & 3 blank.

For any Basic Plan Choice above:

SECTION B **For each eligible dependent,** leave the "PHYSICIAN SELECTION", "PHYS. # or CLINIC NAME", and "Est. Patient" boxes blank.

(The Basic Plan Tier 1 and Tier 2 plans are only available to General City Active Management, Active Sworn Fire Management, Active Sworn Police Management employees, Local 494 (Electrical) MBCTC, HACM/RACM, WCE & MEDC employees)

Complete all appropriate areas of Sections A, B, C, D, and E of the application for all health plan selections.

ALL ENROLLMENT FORMS MUST BE SIGNED AND DATED BY THE EMPLOYEE, THE COBRA ENROLLEE, OR THE RETIREE.

EBA-11

HEALTH ENROLLMENT FORM

CITY OF MILWAUKEE

DER/EMPLOYEE BENEFITS DIVISION

PLEASE TYPE/PRINT FIRMLY - COMPLETE ALL PARTS OF FORM - SIGN

READ ATTACHED INSTRUCTIONS CAREFULLY

OFFICE USE ONLY: GROUP No.: _____
SECTION No.: _____ UN. REP: _____
EMPL ID #: _____ BCU/DU: _____
EFFECTIVE DATE: _____ P.C.: _____
EMP/RET PYMT: _____ PKG. CODE: _____

Section A	Box 1 – Health Plan Selection	Box 2 – Health Center Selection	Box 3 - PHYSICIAN SELECTION & 4 Digit No.	DESIRED COVERAGE	ESTABLISHED PATIENT?	SOCIAL SECURITY NUMBER
			PRIMARY	Single ☐ Family ☐	Yes ☐ No ☐	

APPLICANT (LAST NAME)	(FIRST NAME)	(M.I.)	(HOME ADDRESS)	(CITY)	(STATE)	(ZIP CODE)

JOB TITLE	CITY START DATE	RETURN TO WORK DATE	MARITAL STATUS	SEX	HOME TELEPHONE NUMBER	BIRTH DATE
			SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐	MALE ☐ FEMALE ☐		/ /

Section B – Dependent Enrollment Information

Complete For All Eligible Family Members For Whom You Are Requesting Coverage. Domestic Partner requires pre-registration with the City Clerk's Office

(LAST NAME)	(FIRST NAME)	(M.I.)	SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	RELATIONSHIP	PHYSICIAN SELECTION	PHYS.# or CLINIC NAME	Est Patient?
SPOUSE							PRIMARY		Yes ☐ No ☐
DOMESTIC PARTNER							PRIMARY		Yes ☐ No ☐
DEPENDENT							PRIMARY		Yes ☐ No ☐
DEPENDENT							PRIMARY		Yes ☐ No ☐
DEPENDENT							PRIMARY		Yes ☐ No ☐
DEPENDENT							PRIMARY		Yes ☐ No ☐

Section C – Indicate Purpose For Submitting This Enrollment Application by checking the appropriate box. (In the event of marriage or divorce, please provide name change information)

☐ **INITIAL ENROLLMENT** ☐ **OPEN ENROLLMENT** ☐ **RETURN TO WORK** ☐ **ADD DEPENDENT** ☐ **DELETE DEPENDENT (Name):**

☐ **MARRIAGE** (Provide Date)_____ ☐ **DIVORCE** (Provide date)_____ ☐ **SINGLE TO FAMILY** ☐ **FAMILY TO SINGLE**

Maiden Name: _____ ☐ **NAME CHANGE: FROM:**_____ **TO:**_____ ☐ **DEATH DATE:** ___/___/____ ☐ **OTHER:**

Section D - EVERY APPLICANT MUST COMPLETE THE FOLLOWING INFORMATION. Write in the information requested and/or check the appropriate box.

1.) Is your spouse employed? ☐ YES ☐ NO If "YES", who is the employer? _____ Tel. #

2.) Is anyone named on this application covered under another group health policy? ☐ YES ☐ NO
If "YES", what is the name of the insurance company? _____ Policy Number:

3.) Are you and/or any dependent covered by **MEDICARE**? ☐ YES ☐ NO If "YES", supply a copy of each person's **MEDICARE ID CARD**.

4.) Is anyone named in this application now disabled, mentally incompetent or unable to perform normal work or age-related activities? Yes ☐ No ☐ If yes, please indicate name here. _____

5.) Are there any dependents over age 19 who are full-time students? If so, circle first name in **SECTION B** above. (PLANS MAY REQUIRE VERIFICATION OF DEPENDENT ELIGIBILITY.)

Section E - SIGNATURE BLOCK (This application is not valid without a Valid Signature and Date)

☐ I apply for enrollment under the terms and conditions of my employer's Health Plan as administered by the entity stated in BOX 1 and subject to the authorization on the reverse side. I understand that coverage is not in force until the effective date shown on the ID card issued to me. I authorize any payroll/pension deductions that may be necessary to cover the cost of my plan. To the best of my knowledge, all statements and answers in this application are complete and true.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

NOTICE TO EMPLOYEES AND RETIREES REGARDING THE THIRTY DAY RULE:

Active employees and retired employees are responsible for keeping their enrollment status current – notifying the Employee Benefits Division within 30 days of births, adoptions, marriages (including marriage to another City employee), divorces, dependents ceasing to be dependents, former dependents who become eligible dependents again, deaths and Medicare coverage. New employees must complete health and dental application within 30 days of their City start date and employees returning to work must also complete health and dental applications within 30 days of their returning to work must also complete health and dental enrollment forms within 30 days of their return-to-work date. (Non-compliance with this Thirty-Day Rule may expose the City and/or you to additional costs.) There will be no exceptions to this rule.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION (BASIC PLAN)

By my signature on the reverse side, I hereby authorize:

(1) Any physician, medical practitioner, hospital, clinic, medically related facility or other institution who provided treatment or service to me, my spouse or my minor child(ren) at any time, or their agent(s) (including billing serve) which are subject to the provisions of Sections 146.81-83 of the Wisconsin Statutes, having medical information which includes but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments, and/or services, test results (excluding the results of a test for the present of an antibody to HIV (AIDS virus antibody test), but including x-rays, summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness including pregnancy and treatment of service, if any, for mental or nervous condition, alcohol abuse or drug abuse including: (a) all programs in which the patient has been enrolled as an alcohol or drug abuse patient; and (b) reports of treatment or service rendered for mental illness, developmental disabilities, alcoholism and drug dependence which are subject to provisions of Section 51.30 of the Wisconsin Statute, and

(2) Any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associate having non-medical information about me, my spouse or my minor child(ren).

To disclose to Blue Cross/Blue Shield CMS on the reverse side (the Company) or its representative(s) all such information (including photographic copies thereof), as Blue Cross/Blue Shield CMS may request from time to time.

I understand that said information will be used by Blue Cross/Blue Shield CMS for purposes of payment of claims, third party indemnification, auditing and cost containment measures under the Administrative Services Agreement between Blue Cross/Blue Shield CMS and the City of Milwaukee. I agree that Blue Cross/Blue Shield CMS may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claims(s) or the claim(s) of my spouse or minor child(ren) or as may be otherwise permitted by law or as I may further authorize from time to time.

I further hereby authorize Blue Cross/Blue Shield CMS to furnish and deliver to the City of Milwaukee or its representative(s), in accordance with said Agreement, said information and also the cost of treatments and/or service, dates of said payment(s), recipients of said payment(s) and such other claims information as provided under said Agreement. I understand that such disclosure to the City of Milwaukee is for purposes of payment of claims, third party indemnification, auditing and cost containment measure under said Agreement.

I understand that I may request and receive a copy of this authorization. I understand that this authorization is revocable upon advance written notice given to Blue Cross/Blue Shield CMS at its office, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and Blue Cross/Blue Shield CMS and its directors, officers, employees, and agents shall not be held responsible or liable for such release. I understand that this authorization will remain valid for three years from the date my legal representative or I execute this authorization.

I further understand that a photographic copy of this authorization is as valid as the original.

TERMS AND CONDITIONS (HMO PLANS)

1. I agree to pay in advance the current premium for this health insurance plan and I authorize the City to deduct from my wages, salary, or pension an amount sufficient to provide for regular premium payments that are not otherwise contributed by the City.

2. I agree that any physician, hospital, or other health care provider who attends or has attended me, my spouse, or any of my dependents covered by the health insurance plan, is authorized to furnish the plan, during a period extending to six months following the termination of my enrollment in the plan, with any information from patient health care records for any purpose related to the plan.

3. Any children listed on this application must be unmarried and dependent on me, my spouse, or my former spouse for support and maintenance (as measured by standards employed by the IRS for determining dependency), or be a full-time student in an accredited academic, professional or registered trade school. If over the age of 25, they must be disabled so as to be incapable of self-support.